

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 2 - 1955

State File No. 24360

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 5377	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO				c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. ANTHONY Hosp.				e. STREET ADDRESS (If rural, give location) 16 4335 HUMPHREY			
3. NAME OF DECEASED (Type or Print) DOROTHY SETCHFIELD				4. DATE OF DEATH (Month) (Day) (Year) JUNE 20 1955			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED WIDOW		8. DATE OF BIRTH MAY 12 1885	
9. AGE (In years last birthday) 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNID SW		11. BIRTHPLACE (City and State or Foreign Country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE (Dec'd) JAMES W. SETCHFIELD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS ALICE HARTWIG 7405 SHARON			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Acute Coronary Infarction & Ventricular Fibrillation ANTECEDENT CAUSES Chronic Myocardial Ischemia & Enlargement DUE TO (b) Arteriosclerosis DUE TO (c) Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Arteriosclerosis & Coronary Artery Disease INTERVAL BETWEEN ONSET AND DEATH 2 Mo			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21d. HOW DID INJURY OCCUR? 4201	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from _____, 1955, to June 20, 1955, that I last saw the deceased alive on June 19, 1955, and that death occurred at 10 P.M., from the causes and on the date stated above.			
23a. SIGNATURE Martin J. Glasser		(Degree or title) M.D.		23b. ADDRESS 506 Olive St.		23c. DATE SIGNED 6/20/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE JUNE 24 1955		24c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO	
DATE REC'D BY LOCAL REG. JUN 21 1955		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Rutes 2906 Harris			

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.....
working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No. 39
P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.